

-63-006772

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1400

STATE FILE NUMBER

AMENDED

FILED MAR 15 1969

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3518 Brooklyn		d. STREET ADDRESS (If outside, give location) 3518 Brooklyn	
3. NAME OF DECEASED (Type or print) First ANNA Middle L. Last MC COWEN		4. DATE OF DEATH Month March Day 4 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Westport, N. Y.
13a. FATHER'S NAME George L. Pease		13b. MOTHER'S MAIDEN NAME Laura M. Sheldon	14. NAME OF HUSBAND OR WIFE Frank Mc Cowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address Phil A. Russell 908 W. 96th Ter.
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO (b) Fracture Rt femur DUE TO (c) few years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7:50 A.M. Month, Day, Year 3-4-63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-10-63 to 3-4-63 and last saw her alive on 3-3-63 Death occurred at 7:50 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Print or type) William A. Russell	
22b. ADDRESS 2210 Wornall		22c. DATE SIGNED 3-4-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-6-63	
23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City, Missouri	
24. FUNERAL DIRECTOR ADDRESS Freeman Mortuary Kansas City, Mo.		25. DATE RECD. BY LOCAL REG. 3-4-63	
26. REGISTRAR'S SIGNATURE Ruth H. Long			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

[illegible]

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF
Bellfield Acheson
MEDICAL CERTIFICATION

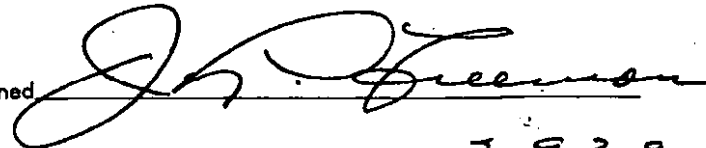
Dr Bellfield Atcheson
7240 Wornall Rd
HI 4-9960
2-5:30

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 2939

P. O. Address H. C. 2410.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

U-07